

Centers for Medicare & Medicaid Services, HHS

§ 455.2

- 455.17 Reporting requirements.
- 455.18 Provider's statements on claims forms.
- 455.19 Provider's statement on check.
- 455.20 Beneficiary verification procedure.
- 455.21 Cooperation with State Medicaid fraud control units.
- 455.23 Suspension of payments in cases of fraud.

Subpart B—Disclosure of Information by Providers and Fiscal Agents

- 455.100 Purpose.
- 455.101 Definitions.
- 455.102 Determination of ownership or control percentages.
- 455.103 State plan requirement.
- 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.
- 455.105 Disclosure by providers: Information related to business transactions.
- 455.106 Disclosure by providers: Information on persons convicted of crimes.

Subpart C—Medicaid Integrity Program

- 455.200 Basis and scope.
- 455.202 Limitation on contractor liability.
- 455.230 Eligibility requirements.
- 455.232 Medicaid integrity audit program contractor functions.
- 455.234 Awarding of a contract.
- 455.236 Renewal of a contract.
- 455.238 Conflict of interest.
- 455.240 Conflict of interest resolution.

Subpart D—Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

- 455.300 Purpose.
- 455.301 Definitions.
- 455.304 Condition for Federal financial participation (FFP).

Subpart E—Provider Screening and Enrollment

- 455.400 Purpose.
- 455.405 State plan requirements.
- 455.410 Enrollment and screening of providers.
- 455.412 Verification of provider licenses.
- 455.414 Revalidation of enrollment.
- 455.416 Termination or denial of enrollment.
- 455.420 Reactivation of provider enrollment.
- 455.422 Appeal rights.
- 455.432 Site visits.
- 455.434 Criminal background checks.
- 455.436 Federal database checks.
- 455.440 National Provider Identifier.
- 455.450 Screening levels for Medicaid providers.
- 455.452 Other State screening methods.
- 455.460 Application fee.

- 455.470 Temporary moratoria.

Subpart F—Medicaid Recovery Audit Contractors Program

- 455.500 Purpose.
- 455.502 Establishment of program.
- 455.504 Definitions.
- 455.506 Activities to be conducted by Medicaid RACs and States.
- 455.508 Eligibility requirements for Medicaid RACs.
- 455.510 Payments to RACs.
- 455.512 Medicaid RAC provider appeals.
- 455.514 Federal share of State expense for the Medicaid RAC program.
- 455.516 Exceptions from Medicaid RAC programs.
- 455.518 Applicability to the territories.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45262, Sept. 29, 1978, unless otherwise noted.

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to beneficiaries.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

(c) Subpart C implements section 1936 of the Act. It establishes the Medicaid Integrity Program under which the Secretary will promote the integrity of the program by entering into contracts with eligible entities to carry out the activities of subpart C.

[51 FR 34787, Sept. 30, 1986, as amended at 72 FR 67655, Nov. 30, 2007]

§ 455.2 Definitions.

As used in this part unless the context indicates otherwise—

§ 455.3

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

- (1) Fraud hotline complaints.
- (2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

42 CFR Ch. IV (10–1–15 Edition)

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

[48 FR 3755, Jan. 27, 1983, as amended at 50 FR 37375, Sept. 13, 1985; 51 FR 34788, Sept. 30, 1986; 76 FR 5965, Feb. 2, 2011]

§ 455.3 Other applicable regulations.

Part 1002 of this title sets forth the following:

(a) State plan requirements for excluding providers for fraud and abuse, and suspending practitioners convicted of program-related crimes.

(b) The limitations on FFP for services furnished by excluded providers or suspended practitioners.

(c) The requirements and procedures for reinstatement after exclusion or suspension.

(d) Requirements for the establishment and operation of State Medicaid fraud control units and the rates of FFP for their fraud control activities.

[51 FR 34788, Sept. 30, 1986]

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

§ 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

[52 FR 48817, Dec. 28, 1987]

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that—

(1) Do not infringe on the legal rights of persons involved; and

(2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3755, Jan. 27, 1983]